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PERSONAL INJURY

DATE:_____

1. Name:_____

   Address:_____

   _____

   Phone: (Home) (____) _____-_____

   (Business) (____) _____-_____

   (Cell) (____) _____-_____

   E-Mail Address:

   How long at present address?_____

2. S.S.#:_____-_____-_____

   Date of Birth:_____

   Driver's License #:_____

3. Occupation:_____

4. Name, address, phone number of employer and how long employed?

   _____

   Was this accident work related: [ ] Yes [ ] No

5. Single:_____ Married:_____ Divorced:____

   Separated:_____ Widowed: _____

6. Spouse's Name (if applicable):_____

7. Number of children or other dependents:

   Children:_____

   Dependents:_____

8. Date of accident:_____

9. Time of accident:_____

10. Were you injured during this accident? [ ] Yes [ ] No

11. Was a Police report filled out for this accident? [ ] Yes [ ] No

If yes, do you have a copy? [ ] Yes [ ] No

Nature and extent of injuries:_____

_____

_____

Immediate effect of injuries (unconsciousness, pain, inability to move or walk, cuts, abrasions, lacerations, bleeding, fracture, and other physical discomforts):_____

_____

_____

Permanent injuries: lists all permanent injuries, including scars, disfigurements, possibility of plastic or remedial surgery:_____

_____

_____

Identify ambulance or other emergency vehicles:_____

First aid or other medical treatment at scene, nature of assistance, and names and addresses of those rendering services:_____

_____

_____

If taken to hospital:

(a) By what means and by whom:_____

(b) Name and address of hospital:_____

(c) Date of admission:_____

(d) Date of discharge:_____

(e) Treatment received and from whom:_____

_____

If taken elsewhere than to hospital, where, by what means, and by whom:_____

_____

X-Rays, EEG, EKG, and other tests:_____

(a) By whom and where:_____

(b) Part of body x-rayed and what x-ray disclosed:_____

(c) Results of EEG, EKG, and other tests:_____

Treatment by doctors and paramedical personnel:

(a) Name and address of each and nature of specialty (orthopedic, therapeutic, surgical, psychiatric, general medical, dental, etc.) _____

_____

_____

(b) Nature and extent of treatment and where given:

Outpatient treatment:

Name and address of hospital:_____

_____

Date and nature of each treatment: _____

Name and address of each doctor, nurse or paramedical personnel: :_____

_____

Medical expenses:_____

Doctor_____

Dates:_____

Total charges:_____

Amount paid to date, and by whom paid:_____

_____

Future or anticipated or anticipated medical treatments: nature, for how long, and estimate of cost:_____

Dates of home confinement:_____

Home nursing care: Name, address and phone of each person :_____

_____

Nature of service:_____

Date performed:_____

Amount paid:_____

Household help: Name, address and phone of each person :_____

_____

Nature of service:_____

Date performed:_____

Amount paid:_____

Present Complaints:_____ _____

_____

_____

Activities limited by injury (hobbies, chores, date to day activities, walking, etc.)_____

_____

If client refused to accept any medical care or treatment recommended by doctors, show the care or treatment refused, doctor involved, date of each refusal, and reasons for refusal:_____

_____

PREVIOUS MEDICAL HISTORY

General conditions of health in last 10 years:_____

_____

Nature, dates, extent of injuries from prior accidents, diseases or other disabling illnesses (heart, lung, brain, kidney-blood, vascular, sight, hearing, speech, dental, surgery, etc.)_____

_____

Names and addresses of doctors involved (include, x-rays, EEG, EKG, and other tests)___

_____

_____

If hospitalized, names and locations of hospitals, duration, and dates of hospitalization ___

_____

Aggravation or effect of present injuries on any existing or prior physical or mental condition:_____

Previous physical exams (prior to accident):_____

Previous accident or injury claims:_____

EMPLOYMENT AND INCOME PRIOR TO ACCIDENT

Name, address, and phone # of employer:_____

Employer's business"_____

Position held and duties:_____

Hours worked: per day_____ per week_____

Hourly pay $_____

Average weekly earnings for preceding 12 months $_____.

Earnings reported on Income Tax Returns for past 2 years:_____

EMPLOYMENT AND INCOME FOLLOWING ACCIDENT

Time lost from work_____

If client returned to work after accident, for each employment, position held and duties___

_____

Hours worked: per day _____ per week _____

Hourly rate $_____

Date of return to full employment_____

If client did not return to work, explain:_____

If injuries impaired or in any manner restricted ability to perform duties of employment or business_____

Lost time since returning to work:

Dates:_____

Periods:_____

Reasons:_____

Income lost:_____

Sick leave used:_____

If a promotion or increase in salary was expected at the time of the accident but did not materialize, give details:_____

If injuries resulted in loss of business income, explain_____

If substituted help was required in client's business to perform all or part of client's duties:

Names Address, Phone numbers of each person :_____

_____

Nature of service:_____

Dates performed:_____

Amount paid:_____

List fellow employees, superiors or business associated who have knowledge regarding client's employment and what each knows:_____

If client lost any rights or benefits related to employment:_____

_____

Nature, extent and source of any other income or pecuniary loss:_____

_____

EDUCATION AND TRAINING

Education background_____

Special skills or Licenses_____

If client's plans or prospects for further education or employment changed as a result of this accident, what are the changes?

_____

_____

SUBSEQUENT INJURIES

If client has been injured since the date of the injury in question, indicate what the injury was, how it was received and hospitals and treating physicians involved_____

_____

_____

WITNESSES

Name(s), address(es) and phone number(s):_____

_____

Location of each witness:_____

Conversations or statements made by witnesses to opposing party, hospital, or police:____

_____

INVESTIGATION

Police called to scene: by whom, identify Officer's name, Badge Number, and Precinct:___

_____

Indicate what arrests were made, Summons issued, or tickets given:_____

_____

Police Report available at:_____

Photos taken at scene:_____

Present location of all vehicles_____

CLIENT'S INSURANCE

Have you notified your insurance carrier? [ ] Yes [ ] No

Automobile: Company name, address, phone, policy # and named insured: _____

_____

Agent's or Broker's name:_____

Limits:_____

Copy of Policy? [ ] Yes [ ] No

Hospitalization: Company name, address, phone, policy # and named insured:_____

_____

Agent's or Broker's name:_____

Limits:_____

Copy of Policy? [ ] Yes [ ] No

Insurance benefits already received:_____

INSURANCE - OTHERS INVOLVED IN ACCIDENT

Names and addresses_____

_____

Company Name:_____

Address:_____

Phone #:_____

Policy Number:_____

Coverage_____

Claims adjuster's name, address and phone #:_____

_____

CLIENT'S PROPERTY DAMAGE

Itemized damage to client's property_____

_____

_____

CHECK LIST

Retainer Agreement_____

Fee Agreement_____

Letter of Representation_____

Request Discovery_____

Copy of: Summons _____

Complaint_____

Warrant_____

Ticket _____

Subpoena_____

Police Report _____

Videotape _____

Repair Bills_____

Request Driver's Abstract:_____

Signed Medical Release Forms_____

Medical Records: Hospital _____

Treating Physicians_____

Photographs_____

Estimates_____

Other_____

SKETCH AND DETAIL OF ACCIDENT

Indicate North

Description:_____

_____

_____

_____

_____

_____

_____

_____

_____